

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

WHEN: When clients desire disclosure of information

ON WHOM: Clients wishing disclosure of medical records

COMPLETED BY: Client or his or her legal representative, and signed by client.
Reference HHSA-L9

**MODE OF
COMPLETION:** Legibly handwritten on form 23-07 HHSA (04/03)

**REQUIRED
ELEMENTS:** All Fields